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QRTips

Behavioral Health Services
Authority and Quality Improvement Services
Quality Assurance & Quality Improvement Division
AOABH / CYPBH / Managed Care / Certification and Designation Support Services Teams

AQIS Top 5 Reasons for Recoupment and Non-Compliance – Part I

AQIS understands how stressful an audit can be, especially with the upcoming triennial State audits. With that in mind, AQIS Support Teams would like to introduce a three-part series to the QRTips called "AQIS Top 5 reasons for recoupment and non-compliance". This series will be divided by topics and distributed in the upcoming monthly QRTips as helpful summaries and suggestions. The information for the topics come from data that was collected from the recent 2020-2021 Fiscal Year. Our goal at AQIS is not only to bring awareness to the most common recoupment and non-compliance issues, but also collaborate with our providers on their journey to strengthen the documentation that supports all the hard work they do.

Top 5 reasons for recoupment and non-compliance for CYPBH

1. Wrong CPT chosen in the progress note (Recoupment)

2. Data Entry Errors (Recoupment)

3. Documentation/Intervention does not address the mental health condition (Recoupment)

4. Timeliness for Assessments and Annual Assessments (Non-Compliance)

5. No documentation that the beneficiary participated in the development of the care plan (Non-Compliance)

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TRAININGS & MEETINGS

AOABH Online Trainings

New Provider Training (Documentation & Care Plan)

2020-2021 AOABH Annual Provider Training

AOABH MHP QI Coordinators' Meeting

WebEx Mtg. 12/2/21 10:30-11:30am

CYPBH Online Trainings

2020-2021 CYPBH Integrated Annual Provider Training

CYPBH MHP QI Coordinators' Meeting

Teams Mtg. 12/9/21 10:00-11:00am

**More trainings on CYPBH ST website*

HELPFUL LINKS

AQIS AOABH Support Team

AQIS CYPBH Support Team

BHS Electronic Health Record

Medi-Cal Certification

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Top 5 reasons for recoupment and non-compliance for AOABH

1. Assessment missing required elements (or Annual Re-Evaluation form completed instead of Psychosocial form after April 2020)
2. Billed under the wrong CPT code
3. SMHS billed during a gap in the Care Plan. Timeliness for assessments and annual assessments
4. No clinical service provided/ non billable services were billed
5. Excessive documentation time

Stay tuned for Part 2 in the next edition of QRTips!

Risk Assessment Reminders

In recent audits of CYPBH County and Contract programs, the AQIS CYPBH Support Team (ST) have noticed some difficulty determining if "risk" has been fully assessed. As a reminder, assessment of risk during the initial and subsequent updates of an assessment is one of the 11 required elements DHCS looks for. With the upcoming 2022 triennial audit just around the corner, CYPBH ST want to ensure that our providers are up to date with the most current regulations pertaining to risk assessment.

DHCS defines risk as "*situations that present a risk to the beneficiary and/or others, including past or current trauma*". Below are examples of what risk in an assessment can look like.

- History of Danger to Self (DTS) or Danger to Others (DTO)
- Previous inpatient hospitalizations for DTS or DTO
- Prior suicide attempts
- Lack of family or other support systems
- Arrest history, if any
- Probation status

- History of alcohol/drug abuse
- History of trauma or victimization
- History of self-harm behaviors (e.g., cutting)
- History of assaultive behavior
- Physical impairments (e.g., limited vision, deaf, wheelchair bound) which make the beneficiary vulnerable to others)
- Psychological or intellectual vulnerabilities (e.g., intellectual disability (low IQ), traumatic brain injury, dependent personality)

Risk Assessment Continued

In addition, a pattern seen in a weak risk assessment is being too vague or not including an identified section where risk is fully assessed. A better risk assessment is identified as being specific, detailed and/or clearly labeled. Please see the example below.

- Vague risk assessment: Client has a history of being psychiatrically hospitalized.
- Better risk assessment: Client has history of being psychiatrically hospitalized two times for danger to self, last reported psychiatric hospitalization was around June 2021 due to intent to overdose and taking approximately 20 aspirins. Client's intrusive thoughts and past abuse trauma place client at continued risk for danger to self.

Finally, it is important to note that integration of the identified risk factors into the case conceptualization is an important and strengthening component of an assessment. In other words, not just listing the risk but formulating how it can impact the beneficiary and treatment moving forward. This can be accomplished by answering the question "**How" will these risk factors impact your treatment of the beneficiary or client's mental health problem**? This will help provide evidence that a comprehensive and well thought out assessment of risk has taken place.

For further resources on the risk and the 11 assessment elements, please refer to the current Annual Provider Training and the Behavioral Health Provider Handbook Coding Manual and Documentation Guidelines, Version 11. For any questions pertaining to this article, please reach out to AQISSupportTeams@ochca.com. Please note that while this article pertains to issues identified in CYPBH, a risk assessment is a required element for CYPBH and AOABH assessments.

Managed Care Support Team

MCST OVERSIGHT

- Notice of Adverse Benefit Determination (NOABDs)
- Appeal/Expedited Appeal/State Fair Hearings
- Clinical Supervision
- PAVE Enrollment for County SUD DMS-ODS Clinics and Providers
- PAVE Enrollment for MHP Providers
- Grievances & Investigations
- County Credentialing
- Cal-Optima Credentialing
- Access Logs
- Change of Provider/2nd Opinions (MHP)
- MHP/SUD DMC-ODS Provider Directories

MCST REMINDERS

CREDENTIALING

- As the MCST rolls out credentialing with the County's health plan network, all program administrators who have completed credentialing their staff must ensure existing/new providers are credentialed. The uniform credentialing and re-credentialing requirements apply to all licensed, waivered, or registered mental health providers and licensed substance use disorder services providers employed by or contracting with the health plan to deliver Medi-Cal covered services.

Expired Certificates of Insurance (COI)

- The provider and/or program administrators receive courtesy e-mail notifications from VERGE (the County's contracted Credential Verification Organization) 30/14/1 day(s) prior to the expiration of the individual or agency COI. To avoid receiving a notification, the provider and/or program administrators must provide the required document to VERGE 30 days prior to the expiration.

Expired Licenses, Certification and Registration

- The MCST has the ability to track and monitor expired credentials for providers who have successfully completed the County credentialing process. Over the last several months there has been a significant rise of providers who have not renewed their expired credentials on time.
- VERGE e-mails notifications to providers 90/60/30 days in advance about expiring licenses, certifications and registrations. After VERGE's multiple attempts to obtain an updated credential MCST and IRIS intervenes to suspend and deactivate the provider. The provider is then no longer permitted to deliver services requiring licensure for the Orange County Health Care Agency.
- When this occurs the provider must immediately petition for their credentialing suspension to be lifted and provide proof of the license, certification and/or registration renewal to MCST and IRIS. The reinstatement is **NOT** automatic.

7-Day Online Attestation for Credentialing

- When the provider begins credentialing, he/she will receive an e-mail from VERGE requesting to complete the online attestation within 7 calendar days to officially start the process.
- If the existing provider does **NOT** complete the attestation within the allotted timeframe MCST and IRIS will intervene to suspend and deactivate the provider. The provider will no longer be permitted to deliver Medi-Cal covered services for the Orange County Health Care Agency until they have completed the credentialing process and show proof of the credential approval letter to IRIS before they can be re-activated to bill for services.

Separation of Credentialed Providers

- Program administrators must notify the MCST within 72 hours when a provider has separated. The MCST will deactivate the provider in order to prevent the County from being charged each month to maintain the separated provider's credential profile.

Managed Care Support Team Cont.

PAVE ENROLLMENT FOR MHP & COUNTY SUD CLINICS ONLY CA.GOV PAVE PORTAL DHCS

- PAVE enrollment and affiliation for County SUD Staff and MHP County Clinics/Contracted Programs was officially transferred over to MCST as of 7/1/21.
- Programs are required to have providers enrolled in PAVE before they can provide any Medi-Cal covered services.
- The providers required to enroll in PAVE are: Nurse Practitioner, LCSW, LMFT, LPCC, Psychologist, MD, DO, Physician Assistant, Pharmacist, Speech Therapist, AOD Counselors and SUD DMC-ODS County Clinics.
- MHP and County SUD Staff/Clinics may send all questions and information to process PAVE enrollment/affiliation to AQISManagedCare@ochca.com with the Subject Line: PAVE Enrollment - _____.
- Any county PAVE enrollment documents and/or forms disseminated prior to 7/1/21 should be discarded since the process has been streamlined and updated. In order to obtain the most current PAVE enrollment information, please e-mail MCST.

PROVIDER DIRECTORY

- All Medi-Cal certified sites are required to provide an updated provider list to the MCST **every month by the 15th**. We ask that you also cc: IRIS (BHSIRISLiaisonTeam@ochca.com) on the monthly submission that went into effect 11/1/21.

GRIEVANCES (MHP ONLY)

- Remember, beneficiaries are able to file a patient rights complaint with Mental Health Systems (MHS) - Patients' Rights Advocacy Services.
- Beneficiaries and/or providers should continue to submit all expressions of dissatisfaction, complaints/grievances regarding HCA Mental Health Plan (MHP) to AQIS/Managed Care Support Team (MCST).
- Grievance and appeal materials along with the two types of self-addressed envelopes (AQIS and PRAS) must be available in the lobby for the beneficiary to pick up without having to make a request.
- The beneficiary has the right to file a grievance with either or both entities.
- PRAS contact information:

mhs MENTAL HEALTH SYSTEMS

600 West Santa Ana Blvd., Suite 805
Santa Ana, CA 92701

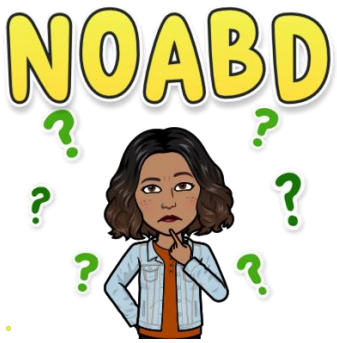
Phone: (714) 276-8145 (800) 668-4240

Fax: (714) 242-1579

Email: ocpras@mhsinc.org

Managed Care Support Team Cont.

NOABD - BENEFICIARY REQUESTING AN APPEAL



- Under federal regulations, an NOABD "Appeal" is a review by the Plan of an Adverse Benefit Determination.
- Federal regulations require beneficiaries to file an appeal within 60 calendar days from the date of when the NOABD was issued.
- When the beneficiary files an NOABD "Appeal" the MCST is required to open an investigation and resolve it within 30 calendar days.
- The program is also required to assist the beneficiary with the continuation of benefits during an appeal of the adverse benefit determination in accordance with federal regulations. This means, the program must keep the case open and continue to provide services until the investigation has been upheld or overturned. **If the appeal has been overturned, the beneficiary continues treatment services with the program.**
- Refer to DHCS MHSUDS Information Notice #18-010E: https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/NOABD%20IN/MHSUDS_IN_18-010_Federal_Grievance_Appeal_System_Requirements.pdf
- Refer to OC HCA Policy and Procedures: https://www.ochealthinfo.com/sites/hca/files/import/data/files/68158.pdf.

CLINICAL SUPERVISION (EFFECTIVE 1/1/22)

- The Board of Behavioral Sciences (BBS) has approved changes to the supervision related regulations that will go into effect January 1, 2022. If you have specific questions related to the changes, please contact BBS for further guidance.
- Refer to the link to view the summary of the BBS Supervision-Related Regulations: https://bbs.ca.gov/pdf/law_changes_2022/supervision_reg_changes.pdf
- The MCST will soon establish a more detailed protocol with a revised Clinical Supervision Reporting Form (CSRF) and require additional supervision documents from all new clinical supervisors/supervisees such as the Supervision Agreement (which replaces the Supervisor Responsibility Statement and Supervisory Plan), Written Oversight Agreement and the Supervisor Self-Assessment Report. At this time, we have not received further guidance and await for the BBS to post more information about the new forms and instructions prior to 1/1/22.

MCST TRAININGS ARE AVAILABLE UPON REQUEST

- If you and your staff would like a specific or a full training about the MCST's oversight and updates on the State and Federal regulations governing Managed Care please e-mail the Program Manager, Annette Tran at anntran@ochca.com.

REMINDERS

Service Chiefs and Supervisors:

Please remember to submit monthly program and provider updates/changes for the Provider Directory and send to: AQISManagedCare@ochca.com

Review QRTips in staff meetings and include in meeting minutes.

Thank you!

***Disclaimer**: The AQIS Quality Assurance (QA) and Quality Improvement (QI) Division develops and distributes the monthly QRTips newsletter to County and County Contracted Behavioral Health providers as a tool to assist with compliance with various QA/QI regulatory requirements. IT IS NOT an all-encompassing document. Programs and providers are responsible for ensuring their understanding and compliance with all local, state, and federal regulatory requirements.*

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